Commonwealth of Massachusetts
Department of Public Health, Bureau of Health Professions Licensure
Drug Control Program
239 Causeway Street, Suite 500, Boston, MA 02114
Telephone 617-973-0949 Fax 617-753-8233

Amended Information Application for Massachusetts Controlled Substances Registration for Physician, Dentist, Podiatrist, and Osteopath

No fee is charged when submitting this *Amended Information Application* form. Please be sure to:

- Complete the first and second page of the application form.
- Sign and date the second page of the application form.
- Mail the aforementioned items to the address above.

The Department will make every effort to process your application as quickly as possible. Please note that processing may take 10 business days from receipt of application. Incomplete applications will be returned and will cause a delay in receiving your MCSR. For further information, visit: http://www.mass.gov/dph/dcp.

Amended Information Application

Please fill out this form in its entirety. Place a check in the box to the left column to indicate information that is being amended.

Amended	In the boxes below enter the requested information.
☐	1) **Degree** (Select one): ☐ MD ☐ DMD ☐ DDS ☐ DO ☐ DPM
☐	2) Massachusetts **Board** of Registration **License No.**:
☐	3) **DEA** Controlled Substance Registration No. (If possessed):
☐	4) List **additonal DEA numbers** and DEA "X" numbers used on prescriptions that might be dispensed in MA pharmacies.
☐	5) **Name**: First: Middle: Last: Suffix: (e.g. Jr., Sr., II, III) Former name (if name change):
☐	6) **Business Address**: Applications that include a P.O. Box number without a street address cannot be processed. Out-of-state addresses require a letter of explanation. Facility Name and Department (if applicable): Street: City: State: ZIP:
☐	7) **Mailing Address**: ☐ Check here if same as above Street: City: State: ZIP:
☐	8) Business **Telephone** No.: ( )
☐	9) **Social Security** No.: (Required by M.G.L. c. 30A, s. 13A)
☐	10) **Drug Schedules** requested: Select all that apply: ☐ II ☐ III ☐ IV ☐ V ☐ VI Schedule VI includes all prescription drugs not in Schedules II - V. Only Schedules that are checked can be authorized.
☐	11) Individual **e-mail** Address:

☐	12) Have you **ever** been **convicted** of any violation of State or Federal law relating to the manufacture,

	possession, distribution or dispensing of controlled substances? ☐ Yes* ☐ No
☐	13) Has any previous professional license or **registration** held by you under any name or corporate name or legal entity been **surrendered**, **revoked**, **suspended** or denied or is such action pending? ☐ Yes* ☐ No
* **If** you answered "**Yes**" to Question No. 12) or No. 13), a letter must be attached setting forth circumstances of such action(s).	

Applicant please sign and date below

I hereby certify that the information on this application is true to the best of my knowledge, and that I will comply with the laws of the Commonwealth of Massachusetts and all applicable rules and regulations promulgated by the Department of Public Health. I also certify, in accordance with M.G.L. c. 62C, s. 49A, that I have to the best of my knowledge and belief filed all state tax returns and paid all state taxes required under law. Signed under the pains and penalties of perjury.

Signature of applicant (no initials) ✘ _____ Date ✘ _____

MCSR Amended Information Application Form Instructions

These instructions follow the application form sequentially. If you need additional guidance contact the Drug Control Program (DCP) at 617-973-0949.

Questions:

1. Select your professional degree.
2. Fill in your personal Board of Registration license number.
3. Fill in your personal DEA registration number.
4. If you issue prescriptions using multiple DEA numbers or DEA "X" numbers at different times and locations, providing those to DCP will help ensure that you retrieve more complete prescription history reports listings from the Massachusetts Prescription Awareness Tool (MassPAT).
5. Include your complete middle name (no initials), and a suffix, if applicable.
6. Fill in your business address.
7. Fill in your mailing address. If you do not use fill in a mailing address, all mailings will go to your business address.
8. Fill in the phone number at which you can be reached. Please be mindful that this phone number would be used should DCP need to contact you or should prescribers or pharmacists need to consult with you regarding MassPAT prescription histories.
9. Enter your social security number.
10. Check off the drug schedule privileges you are requesting. If you check of a higher schedule and leave any lower schedules unchecked, you will be granted privileges for the lower schedule also. For example, if you check off only Schedule II, you will also be granted privileges for Schedules III – VI.
11. Please provide an email address that you monitor frequently.
12. Check the "Yes" or the "No" box. If checking the "Yes" box, include a letter of explanation.
13. Check the "Yes" or the "No" box. If checking the "Yes" box, include a letter of explanation.